DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155171	A. BUILDING 00 B. WING	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MEADOWS	1285 W JEFFERSON ST FRANKLIN, IN46131

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F0000	This visit was for Investigation of Complaints IN00099148 and IN00099246. Complaint IN00099148 Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323. Complaint IN00099246 Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies cited Survey date: November 28 & 29, 2011 Facility number: 000087 Provider number: 155171 AIM number: 100289890 Survey team: Mary Jane G. Fischer RN Census bed type: SNF/NF: 106 Total: 106 Census payor type: Medicare: 11 Medicaid: 74 Other: 21	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after December 29, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

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	Total: 106 Sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on November 20, 2011 by Bev Faulkner, RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a physician's order for a bed sensor alarm was followed for 1 of 5 residents reviewed for physician orders in the sample of 5. [Resident "A"]. Findings include: The record for Resident "A" was reviewed on 11-28-11 at 10:05 a.m. Diagnoses included but were not limited to Clostridium difficile, dementia, hypertension, intercranial hemorrhage, and history of urinary tract infection. These diagnoses remained current at the time of the record review. Review of the resident's Minimum Data Set Assessment, dated 07-02-11 indicated	F0282	**F 282 SERVICES PROVIDED BY A QUALIFIED PERSON/PER CARE PLAN** It is the practice of this facility to ensure services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	12/29/2011

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	the resident was totally dependent for bed mobility and required two + staff persons for repositioning needs. Although the resident did not have a fall prior to admission, the assessment indicated "resident is at risk for falls due to gait/balance, medications, incontinence, new admission and confusion. Res. [resident] has had recent CVA [cerebral vascular accident - has a history of dementia and poor cognitive skills and safety awareness. Res. is non ambulatory at this time, res. is transferred with assistance. Fall interventions include pressure alarm in bed, non skid footies or shoes when up, half noodle under lateral edge of mattress, half side rails in grab bar position to assist with bed mobility." A physician order, dated 06-21-11, instructed the nursing staff to implement "bed sensor alarm, check for placement every shift, non skid footies/shoes when up." Physician orders, dated 06-22-11, included "landing strip next to bed, 1/2 noodle to right lateral side of bed under mattress secondary to decreased safety awareness, increased fall risk." A review of the "Event Report," dated 07-03-11 at 10:25 p.m., indicated the resident had an unwitnessed fall, and was		Resident (A) no longer resides in this facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** Residents with an order for a bed sensor alarm have the potential to be affected by the alleged deficient practice. The DNS/designee will complete an audit by 12/12/11 to ensure all residents that have a physicians order for a bed sensor alarm have the bed sensor alarm in place. The Staff Development Coordinator/designee will in-service nursing staff by 12/20/11. Licensed nurses will be educated on following physicians orders to ensure interventions are in place, this will include bed sensor alarms. Licensed staff also	

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	found lying on back on landing pad adjacent to the bed. "Interventions put into place to prevent another fall - pressure pad alarm applied." The "Event Report," progress notes detailed the following: "Resident found on pad on floor next to bed - resident assessed for pain or injury both negative. Nursing neurochecks wnl [within normal limits], physician faxed infor. [information] on event, spoke with [family member] on phone [family member] seemed non problematic with event after explaination [sic] of reactive measures which include placing a pressure pad alarm under resident while in bed." A subsequent notation, dated 07-05-11 at 10:24 a.m., indicated "New intervention to include placing low bed. Resident's current interventions include pressure alarm in bed, non skids when up, 1/2 noodle to right lateral side of bed under mattress, 1/2 side rails in grab bar position, landing strip next to bed." On 11-29-11 at 11:30 a.m., the Corporate Nurse Consultant employee #5, reviewed the "Event Report" and the physician order, and then indicated it appeared the bed sensor was applied as a "reactive" measure after the resident had fallen.		responsible for providing an immediate intervention that is not already a part of the resident care plan. Unlicensed nursing staff educated on following the resident assignment sheet to ensure all interventions are in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Staff Development Coordinator/designee will in-service nursing staff by 12/20/11. Licensed nurses will be educated on following physicians orders to ensure interventions are in place, this will include bed sensor alarms. Licensed staff also responsible for providing an immediate intervention that is not already a part of the resident care plan. Unlicensed nursing staff educated on following the	

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	During a subsequent interview on 11-29-11 at 2:00 p.m., the Director of Nurses indicated she was unaware if the bed sensor alarm had been implemented. Although the original physician orders and interventions included the use of a pressure alarm while the resident was in bed, the nursing staff failed to implement the assistive device to alert the nursing staff of unassisted ambulation or transfer of the resident. This Federal tag relates to Complaint IN00099148. 3.1-35(g)(2)		resident assignment sheet to ensure all interventions are in place. Post tests will be administered to ensure understanding of in-service provided. Unit managers/charge nurse will make rounds every shift to ensure that proper fall prevention interventions are in place. These rounds will be documented and reviewed daily. Any interventions not in place will immediately be corrected by unit manager/charge nurse. Staff not ensuring fall interventions in place will be disciplined accordingly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed**	

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			A CQI tool will be utilized by the SDC/designee to monitor the proper use of bed sensor alarms weekly x4, bi-weekly x2, and monthly thereafter until compliance has reached 100% for 90 days. The CQIs will be reviewed monthly by the CQI Committee. If at any time the threshold falls below 95% an action plan will be initiated. Non-compliance in this practice will result in education and/or disciplinary action of the responsible employee.	
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure the implementation of assistive devices, in that when a resident was assessed as a fall risk and interventions had been established, the nursing staff failed to ensure the implementation of an alarm to alert the nursing staff of unassisted ambulation/unsafe movement, which resulted in a fall for 1 of 4 resident's reviewed for falls in a sample of 5. [Resident "A"].	F0323	**F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES** It is the practice of this provider to ensure that all alleged violations involving free of accident/hazards/supervision/devices are provided in accordance with State	12/29/2011

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	Findings include: The record for Resident "A" was reviewed on 11-28-11 at 10:05 a.m. Diagnoses included but were not limited to Clostridium difficile, dementia, hypertension, intercranial hemorrhage, and history of urinary tract infection. These diagnoses remained current at the time of the record review. Review of the resident's Minimum Data Set Assessment, dated 07-02-11, indicated the resident was totally dependent for bed mobility and required two + staff persons for repositioning needs. Although the resident did not have a fall prior to admission, the assessment indicated "resident is at risk for falls due to gait/balance, medications, incontinence, new admission and confusion. Res. [resident] has had recent CVA [cerebral vascular accident - has a history of dementia and poor cognitive skills and safety awareness. Res. is non ambulatory at this time, res. is transferred with assistance. Fall interventions include pressure alarm in bed, non skid footies or shoes when up, half noodle under lateral edge of mattress, half side rails in grab bar position to assist with bed mobility." The resident's plan of care, updated on		and Federal law through established procedures. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Resident (A) no longer resides in this facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** All residents have the potential to be affected by this alleged deficient practice. An in-service will be conducted for all nursing personnel by 12/20/11 by the facility SDC/designee regarding fall prevention, implementation of assistive devices such as bed sensor alarms, checking placement and function of assistive	

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	07-06-11, indicated "Fall risk related to gait/balance, CVA, medications and diagnoses." Interventions included Low bed, encourage to use call light, fall risk assessment, provide appropriate assistive devices such as pressure alarms in bed, landing strips on floor next to bed, half noodle under lateral edge of mattress, non skid footies or shoes when up." Review of the Physical Therapy initial assessment, dated as SOC [Start of Care] 06-21-11, indicated "Precautions: fall risk." The Occupational Therapy initial assessment, dated as SOC 06-22-11, indicated "Precautions: "fall risk." A physician order, dated 06-21-11, instructed the nursing staff to implement "bed sensor alarm, check for placement every shift, non skid footies/shoes when up." Physician orders, dated 06-22-11, included "landing strip next to bed, 1/2 noodle to right lateral side of bed under mattress secondary to decreased safety awareness, increased fall risk." A review of the "Event Report," dated 07-03-11 at 10:25 p.m., indicated the resident had an unwitnessed fall, and		devices every shift, and utilization of resident care sheets by the cna to ensure all fall interventions are in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** An in-service will be conducted for all nursing personnel by 12/20/11 by the facility SDC/designee regarding fall prevention, implementation of assistive devices such as bed sensor alarms, checking placement and function of assistive devices every shift, and utilization of resident care sheets by the cna to ensure all fall interventions are in place. The DNS/designee will complete an audit by 12/12/11 to ensure all residents that have a physicians order for a bed sensor alarm have the bed sensor alarm in place. Unit managers/charge nurse will make rounds every shift to	

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	found lying on back on landing pad adjacent to the bed. "Interventions put into place to prevent another fall - pressure pad alarm applied." The "Event Report," progress notes detailed the following: "Resident found on pad on floor next to bed - resident assessed for pain or injury both negative. Nursing neurochecks wnl [within normal limits], physician faxed infor. [information] on event, spoke with [family member] on phone [family member] seemed non problematic with event after explaination [sic] of reactive measures which include placing a pressure pad alarm under resident while in bed." A subsequent notation, dated 07-05-11 at 10:24 a.m., indicated "New intervention to include placing low bed. Resident's current interventions include pressure alarm in bed, non skids when up, 1/2 noodle to right lateral side of bed under mattress, 1/2 side rails in grab bar position, landing strip next to bed." Review of the Treatment Order Record," for the month of July 2011 lacked documentation the assistive device bed sensor alarm had been checked for placement and function on July 2, the 3 - 11 shift, and July 3rd - 11- 7 shift as well		ensure that proper fall prevention interventions are in place. These rounds will be documented and reviewed daily. Any interventions not in place will immediately be corrected by unit manager/charge nurse. Staff not ensuring fall interventions in place will be disciplined accordingly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed:** A fall management CQI audit tool will be completed once weekly x4, bi-weekly x2, and then monthly thereafter by a facility Unit Manager/designee. The fall management CQIs will be reviewed monthly by the CQI Committee 90 days	

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	as the 7 - 3 shift. The documentation included a staff members "initial" that was circled on July 3rd for the 3 - 11 shift. The reverse side of the treatment order record lacked an explanation of the circled entry. On 11-29-11 at 11:30 a.m., the Corporate Nurse Consultant employee #5, reviewed the "Event Report" and the physician order, and then indicated it appeared the bed sensor was applied as a "reactive" measure after the resident had fallen. During a subsequent interview on 11-29-11 at 2:00 p.m., the Director of Nurses indicated she was unaware if the bed sensor alarm had been implemented. Although the original physician orders and interventions included the use of a pressure alarm while the resident was in bed, the nursing staff failed to implement the assistive device to alert the nursing staff of unassisted ambulation or transfer of the resident. This Federal tag relates to complaint IN00099148. 3.1-45(a)(2)		after which the CQI team will re-evaluate the continued need for the audit. If at any time the threshold falls below 95% an action plan will be initiated. Non-compliance in this practice will result in education and/or disciplinary action of the responsible employee.	

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on record review and interview, the facility failed to ensure the accurate documentation of a communicable transmission condition, in that when a resident was identified with head lice, the	F0441	**F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS** It is the practice of this	12/29/2011

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	infection control coordinator failed to include the information in the monthly infection control surveillance data for 1 of 1 residents reviewed for head lice in a sample of 5 and 1 of 1 infection control surveillance programs reviewed. [Resident "E"]. Findings include: The record for Resident "E" was reviewed on 11-29-11 at 1:50 p.m. Diagnoses included but were not limited to multiple sclerosis, depressive disorder, and anxiety. These diagnoses remained current at the time of the record review. Review of an "Event Report," dated 10-29-11, indicated "Infection Control Individual Report. Other signs and symptoms - live bugs. Medication ordered Kwell Shampoo x's 1 now again in 7 days. Notes: Hair tx. [treatment] done per MD [Medical Doctor] order. Res. [resident] tol. [tolerated] well. Bedding and personal items treated as well. Nits and bugs removed by hand." Interview on 11-29-11 at 1:30 p.m., the Director of Nurses verified resident "E" was identified with head lice, and subsequently treated. The facility "Conditions & Infections		facility that an established Infection Control Program is maintained and designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Resident (E) was added to the infection control surveillance data for the month of October 2011. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** All residents have the potential to be affected by the alleged deficient	

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	Precaution Recommendations," reviewed on 11-29-11 at 2:10 p.m., indicated "Lice: Head (pediculosis) - contact isolation. Follow physician orders for shampoo treatment - use gowns & gloves during treatment." Review of the Infection Control Surveillance Data on 11-28-11 at 11:00 a.m., for the month of October 2011 lacked information related to the resident and the treatment received for head lice. Interview on 11-29-11 at 2:30 p.m., with the Regional Director of Nursing Services indicated the surveillance data should have included the information related to the resident identified with head lice. 3.1-18(b)(1)(A)		practice. The infection control coordinator was educated by the Director of Nursing Services on 11/30/11 to include any occurrence of head lice on the monthly infection control surveillance data. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The infection control coordinator will utilize the daily surveillance log for all infections. All infections are reviewed by the interdisciplinary team Monday through Friday, excluding holidays. Infection control coordinator compiles information on to the infection control tracking map at the end of every month. The infection control coordinator was educated by the Director of Nursing Services on 11/30/11 to	

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F9999			include any occurrence of head lice on the monthly infection control surveillance data. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed** The daily surveillance investigation log and facility tracking map will be reviewed monthly by the CQI committee to ensure compliance with all infections identified, including head lice. Non-compliance in this practice will result in education and/or disciplinary action of the responsible employee.	

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	3.1-13 ADMINISTRATION AND MANAGEMENT (g) The Administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1)Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including but not limited to any: (D) major accident. This State rule was not met as evidenced by: Based on observation, interview and record review, the facility failed to immediately notify the State Agency of an incident, in that when a dependent resident fell from bed and sustained bruising, laceration and a fractured nose, the facility failed to immediately inform the division by telephone, followed by a written notice within twenty-four (24) hours, of the unusual occurrence for 1 of 4 residents reviewed for falls in a sample of	F9999	**F 9999 FINAL OBSERVATIONS** It is the policy of this facility to report unusual occurrences that directly affect the welfare, safety or health of the resident or residents, including but not limited to major accidents. **What corrective action(s) will be accomplished for those residents foundto have been affected by the deficient practice** The Executive Director and Director of Nursing Services will be re-educated on the Indiana State Regulations related to reporting unusual occurrences by our Corporate Clinical Nurse Specialist by 12/16/11 . **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** Unusual occurrences will be reported per State and Federal Guidelines. Each unusual occurrence will be reported to the Clinical Nurse Specialist to ensure proper reporting occurs. **What measures will be put into place or what systemic changes will bemade to ensure that the deficient practice does not recur** The unusual occurrence reporting policy has been reviewed by the Executive Director and Director of Nursing Services. The Executive Director and Director of Nursing Services will consult with the Clinical Nurse Specialist regarding unusual	12/29/2011

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	155171	A. BUILDING 00 B. WING	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	5. [Resident "C"]. Findings include: The record for Resident "C" was reviewed on 11-28-11 at 11:10 a.m. Diagnoses included but were not limited to dementia, hypertension, diabetes mellitus and a history of hip replacement surgery. These diagnoses remained current at the time of the record review. The resident's Minimum Data Set Assessment, dated 10-07-11, indicated the resident was severely cognitive impaired and required extensive assistance of 2 + staff members for transfer and bed mobility. During an observation on 11-28-11 at 9:15 a.m., the resident was observed seated in a Broda chair. The resident was observed with a black eye. Interview on 11-28-11 at 9:15 a.m., Licensed Practical Nurse employee # 2 indicated the resident fell from bed and fractured [resident] nose." The Licensed Nurse further indicated the resident required "total care." Review of an "Event Report," dated 11-12-11 at 3:43 a.m., indicated the following: "Resident was changed by Aide and nurse		occurrences to ensure timely reporting. Unusual occurrences will be reported to the appropriate agencies within 24-hours. The Executive Director and DNS will be re-educated on the proper policy and procedure regarding unusual occurrences for Residents. **How the corrective action(s) will be monitored to ensure the deficientpractice will not recur, i.e., what quality assurance program will be putinto place; and by what date the systemic changes will be completed** An abuse prohibition and investigation CQI tool will be completed weekly x4 and monthly x6 by the Executive Director. The CQIs will be reviewed monthly by the CQI Committee for compliance and determine a need for further action and/or review. If at any time the threshold falls below 100% an action plan will be initiated.	

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	at 2:15 a.m. Nurse was then standing outside door at 2:30 a.m. when heard resident moaning. Nurse found resident on floor face down. [Resident] had lacerated forehead and nose. Nose was swollen and red. DON [Director of Nurses] notified and physician called. Sent to hospital via paramedics." The report further indicated the resident had a "laceration about 1 inch wide above the nose to forehead. Laceration 1/2 inch to bridge of nose with swelling and deformity - unwitnessed fall." The physician progress notes, dated 11-12-11, indicated the resident had a fractured nose related to the fall. The Interdisciplinary notation, dated 11-14-11, indicated the resident received 6 stitches to forehead and 3 to nose." Review of the confirmation notification of the report to the State Agency indicated "incident 11-12-11" and "reported to the State Agency on 11-16-11 at 17:59 [5:59] p.m." Review on 11-29-11 at 11:40 a.m., of the facility "Risk Management - Resident and Visitor Unusual Occurrences," undated, indicated the following:			

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	"Definition of Unusual Occurrence/Event [underscored]" "An unusual occurrence/event is defined as any happening not consistent with the routine operation of the nursing facility, which may have caused or may have the potential for causing injury to residents, visitors, or loss or damage of property." "Serious events [bold type]" "Serious events fall into one or both of two categories: 1.) Occurrences that result in resident or visitor injuries and/or death: and 2) Occurrences that are likely to result in claims loss. Serious events are categorized into two groups that designate to whom the events are to be reported." "A. Events that are required to be reported to the Director of Operations, DNS [Director of Nursing Services] specialist, and Director of Clinical Services and ISDH [Indiana State Department of Health]. These events must be reported to the ISDH within 24 hours of occurrence and followed by a written report within 5 days of the occurrence." "6. SIGNIFICANT INJURIES - Examples, but not all inclusive: Injuries sustained while a resident was physically restrained, large areas of contusions (greater than 10 cm), large			

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	lacerations/skin tears (greater than 10 cm), fractures sustained by a totally dependent resident as defined by the MDS [minimum data set assessment]." During interview on 11-29-11 at 3:00 p.m., the Director of Nurses indicated the resident had a ROHO mattress and believed the resident slid from the edge of the mattress and onto the floor. In addition the Director of Nurses indicated she failed to immediately report the incident because she was "aware" how the incident happened even though it was unwitnessed, but later due to the extent of the injuries, reported the incident to the State Agency. 3.1-13(g)(1)(D)			